BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT VAVRICK, M.D.** Holder of License No. 14500 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-06-0945B **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Robert Vavrick, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

ROBERT VAVRICK, M.D. DATED: 5/16/07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 14500 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0945B after receiving notification of a malpractice settlement involving Respondent's care and treatment of a forty-five year-old female patient ("DL").

4. DL had a long history of migraine headaches. On February 20, 2002, DL presented to a clinic with a sinus headache, was diagnosed with sinusitis and was prescribed Biaxin.

5. On February 22, 2002, DL presented to the emergency department ("ED") complaining of slurred speech, decreased level of consciousness, and an inability to walk without assistance. Respondent examined DL. DL's daughter informed Respondent that she had taken four Tylenol #3 prior to presenting; however, it was accidental and she did not attempt to harm herself. DL was alert and was able to confirm the information provided to Respondent. Respondent treated DL with charcoal for the overdose and elected to observe her in the ED for several hours. After four hours, DL was no longer somnolent and did not have slurred speech, but her headache returned. Respondent prescribed Lortab and within forty minutes DL improved. Respondent discharged DL with a prescription for Lortab and to follow up with the on-call family practice physician.

6. On March 2, 2002, DL was found unresponsive and was transported to the ED by ambulance. The on-duty physician ordered a computed tomography ("CT") scan of her head demonstrating a cerebral hemorrhage with blood in the parenchyma and

ventricles that was most pronounced in the anterior cerebral artery. There was also evidence of hydrocephalus.

7. On March 21, 2002, DL underwent a craniotomy with an operative cerebral angiogram demonstrating an aneurysm of the left anterior communicating artery. The aneurysm was clipped and the bleeding stopped. DL survived the procedure, but suffered severe brain damage.

8. When a patient presents with headaches and an altered level of consciousness, the standard of care requires a physician to order appropriate CT testing and lumbar puncture to rule out an occult bleed or an infection.

9. Respondent deviated from the standard of care because he failed to order a head CT and lumbar puncture to rule out an occult bleed or infection in DL whose chief complaint was decreased level of consciousness and acute headache.

10. Respondent's failure led to a delay in diagnosing DL with an intracranial hemorrhage that resulted in permanent brain damage and could have led to DL's death.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to order a head CT and lumbar puncture for a patient with altered level of consciousness and acute headache.

2. This Order is the final disposition of case number MD-06-0945B.

DATED AND EFFECTIVE this 8th day of June, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of June, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 8th day of June, 2007 to:

Robert A. Vavrick, M.D.
Address of Record

_____
Investigational Review